**CHECKLIST FOR GROUP STAND-ALONE VISION AND DENTAL PRODUCTS**
**Pursuant to the Requirements of M.G.L. c. 176O and 211 CMR 52.00**
**& Chapter 162 of the Acts of 2005**

**NOTE TO CARRIERS COMPLETING THIS CHECKLIST:**
***Pursuant to Bulletin No. 2001-05, please include a completed checklist when submitting an application for an insured preferred provider plan.***

***When completing this checklist, please indicate for each requirement the page number(s), and/or section(s), where the required information may be found in the submitted materials.***

- ***For items requiring company confirmation, please place a checkmark (√) next to the requirement acknowledging confirmation.***
- ***If a requirement is not applicable (N/A), please place "N/A" next to the requirement and explain, either within the checklist or on a separate sheet, the legal basis under which the requirement does not apply to the filed materials.***
- ***Please review Chapter 162 of the Acts of 2005 and Bulletin 2006-03.***

**Date:** _____

**Carrier Name & NAIC #:** _____

**Contact Name & Title:** _____

**Address:** _____

**Telephone & Fax:** _____

**Email Address:** _____

**Product Name & Form #:**
**(Attach a separate sheet if necessary.)** _____

**Carrier Certification:**

I, _____ a duly authorized representative of_____ certify that it is my good faith belief based on the review of this checklist and submitted materials that the submitted materials comply with applicable Massachusetts law.

**FOR DIVISION OF INSURANCE USE ONLY:**

**Date Received:** _____

**Reviewed by:** _____

## APPLICABILITY [211 CMR 52.02]:

Certain requirements of 211 CMR 52.00 et seq., as specified herein, shall also apply to dental and vision carriers. Such provisions are: 211 CMR 52.12(1) through (4); 211 CMR 52.12(11); 211 CMR 52.13(2); 211 CMR 52.13(3)(a), (c) through (e), (g) through (i), (m) through (p); 211 CMR 52.13(4) through (10); 211 CMR 52.14(1)(c) and (d); 211 CMR 52.14(2), (3) and (7); and 211 CMR 52.18.

## DEFINITIONS (if used) [211 CMR 52.03]:

_____ Carrier, an insurer licensed or otherwise authorized to transact accident or health insurance under M.G.L. c. 175; a nonprofit hospital service corporation organized under M.G.L. c. 176A; a nonprofit medical service corporation organized under M.G.L. c. 176B; a health maintenance organization organized under M.G.L. c. 176G; and an organization entering into a preferred provider arrangement under M.G.L. c. 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer. Unless otherwise noted, the term "carrier" shall not include any entity to the extent it offers a policy, certificate, or contract that provides coverage solely for dental care services or vision care services.

_____ Dental carrier, an insurer licensed or otherwise authorized to transact accident or health insurance under chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a nonprofit medical service corporation organized under chapter 176B; a dental service corporation organized under chapter 176E, or an organization entering into a preferred provider arrangement under chapter 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer, that offers a policy, certificate or contract that provides coverage solely for dental care services.

_____ Dental benefit plan, a policy, contract, certificate or agreement of insurance entered into, offered or issued by a dental carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs solely for dental care services.

_____ Dental care professional, a dentist or other dental care practitioner licensed, accredited or certified to perform specified dental services consistent with the law.

_____ Dental care provider, a dental care professional or facility.

_____ Dental care services, or dental services, services for the diagnosis, prevention, treatment, cure or relief of a dental condition, illness, injury or disease.

_____ Health benefit plan, a policy, contract, certificate or agreement of insurance entered into, offered or issued by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. Unless otherwise noted, "health benefit plan" shall not include a dental benefit plan or a vision benefit plan.

_____ Material change, a modification to any of a carrier's, including a dental or vision carrier's procedures or documents required by 211 CMR 52.00 that substantially affects the rights or responsibilities of an insured, carrier, including a dental or vision carrier, or health, dental or vision care provider.

_____ Network, a group of health, dental or vision care providers who contract with a carrier, including a dental or vision carrier, or affiliate to provide health, dental or vision care services to insureds covered by any or all of the carrier's, including a dental or vision carrier's or affiliate's plans, policies, contracts or other arrangements. Network shall not mean those participating providers who provide services to subscribers of a nonprofit hospital service corporation organized under M.G.L. c. 176A, or a nonprofit medical service corporation organized under M.G.L. c. 176B.

_____ Participating provider, a provider who, under a contract with the carrier, including a dental or vision carrier, or with its contractor or subcontractor, has agreed to provide health, dental or vision care services to insureds with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the carrier, including a dental or vision carrier.

_____ Service area, the geographical area as approved by the Commissioner within which the carrier, including a dental or vision carrier, has developed a network of providers to afford adequate access to members for covered health, dental or vision services.

_____ Vision carrier, an insurer licensed or otherwise authorized to transact accident or health insurance under chapter 175; an optometric service corporation organized under chapter 176F, or an organization entering into a preferred provider arrangement under chapter 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer, that offers a policy, certificate or contract that provides coverage solely for vision care services.

_____ Vision benefit plan, a policy, contract, certificate or agreement of insurance entered into, offered or issued by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs solely for vision care services.

_____ Vision care professional, an ophthalmologist, optometrist or other vision care practitioner licensed, accredited or certified to perform specified vision services consistent with the law.

_____ Vision care provider, a vision care professional or facility.

_____ Vision care services, or vision services, services for the diagnosis, prevention, treatment, cure or relief of a vision condition, illness, injury or disease.

## STANDARDS FOR CREDENTIALING [211 CMR 52.14(7) - M.G.L. C. 176O §15(I)]:

A carrier, including a dental or vision carrier, shall provide to a health, dental or vision care provider, a written reason or reasons for denying the application of any health, dental or vision care provider who has applied to be a participating provider.

_____ **Please confirm that the carrier complies with this requirement**

## STANDARDS FOR PROVIDER CONTRACTS [211 CMR 52.12]:

**211 CMR 52.12(1) - M.G.L. c. 176O, § 4**

Contracts between carriers and providers **shall state** that a carrier shall not refuse to contract, or compensate for covered services, with an otherwise eligible health care provider solely because such provider has in good faith:

_____ (a) communicated with or advocated on behalf of one or more of his prospective, current or former patients regarding the provisions, terms or requirements of the carrier's health benefit plans as they relate to the needs of such provider's patients; or

_____ (b) communicated with one or more of his prospective, current or former patients with respect to the method by which such provider is compensated by the carrier for services provided to the patient.

**Please identify the section(s) and page number(s) of the provider contracts(s) that address this requirement.**

**211 CMR 52.12(2) - M.G.L. c. 176O, § 5**

Contracts between carriers and providers **shall state** that the provider is not required to indemnify the carrier for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the carrier based on the carrier's management decisions, utilization review provisions or other policies, guidelines or actions.

_____ **Please identify the section(s) and page number(s) of the provider contracts(s) that address this requirement.**

**211 CMR 52.12(3) - M.G.L. c. 176O, § 10(a)&(b)**

No contract between a carrier and a licensed health care provider group may contain any incentive plan that includes a specific payment made to a health care professional as an inducement to reduce, delay or limit specific, medically necessary services covered by the health care contract.

_____ (a) Health care professionals shall not profit from provision of covered services that are not medically necessary or medically appropriate.

_____ (b) Carriers shall not profit from denial or withholding of covered services that are medically necessary or medically appropriate.

_____ (c) Nothing in 211 CMR 52.12(3) shall be construed to prohibit contracts that contain incentive plans that involve general payments such as capitation payments or shared risk agreements that are made with respect to providers or which are made with respect to groups of insureds if such contracts, which impose risk on such providers for the costs of care, services and equipment provided or authorized by another health care provider, comply with 211 CMR 52.12(4).

**Please identify the section(s) and page number(s) of the provider contracts(s) that address this requirement.**

_____ **211 CMR 52.12(4)**

No carrier may enter into a new contract, revise the risk arrangements in an existing contract, or after July 1, 2001, revise the fee schedule in an existing contract with a health care provider which imposes financial risk on such provider for the costs of care, services or equipment provided or authorized by another provider unless such contract includes specific provisions with respect to the following:

(a) stop loss protection,

(b) minimum patient population size for the provider group, and
(c) identification of the health care services for which the provider is at risk.

**Please provide a statement that advises whether the carrier has issued new contracts as described above, and if so, reference the section(s) of the provider contract that address 211 CMR 52.12(4)(a)-(c).**

_____ **211 CMR 52.12(11)**

Nothing in 211 CMR 52.12 shall be construed to preclude a carrier from requiring a health care provider to hold confidential specific compensation terms.

**Please identify the section(s) and page number(s) of the provider contracts(s) that address this requirement.**

## PROMPT PAYMENT

**(see also M.G.L. c. 176A, § 8(e); M.G.L. c. 176B, § 7; M.G.L. c. 176G, § 6; M.G.L. c. 176I, § 2)**

_____ According to M.G.L. c. 175, § 110(G), "[w]ithin forty-five days from . . . receipt of notice [of a claim by a claimant] if payment is not made the insurer shall notify the claimant in writing specifying the reasons for the nonpayment or whatever further documentation is necessary for payment of said claim within the terms of the policy. If the insurer fails to comply with the provisions of this paragraph, said insurer shall pay, in addition to any benefits which inure to such claimant or provider, interest on such benefits, which shall accrue beginning forty-five days after the insurer's receipt of notice of claim at the rate of one and one-half percent per month, not to exceed eighteen percent per year. The provisions of this paragraph relating to interest payments shall not apply to a claim which an insurer is investigating because of suspected fraud."

**Please identify the section(s) and page number(s) of the provider contracts(s) that clearly identify the above-noted statute** (See also Bulletin 00-13)

## EVIDENCES OF COVERAGE [211 CMR 52.13 - M.G.L. c. 176O, § 6(b)]:

Dental and vision carriers shall issue and deliver to at least one adult insured in each household residing in Massachusetts, upon enrollment (i) an evidence of coverage, (ii) a summary of the information contained in the evidence of coverage, or (iii) refer the insured to resources where the information described in such evidence of coverage can be accessed, including, but not limited to, an internet website. Dental and vision carriers shall be exempt from the provisions of 211 CMR 52.13(3)(b), 211 CMR 52.13(3)(f), 211 CMR 52.13(3)(j) through (l) and 211 CMR 52.13(3)(q) through (y). The evidence of coverage shall contain a clear, concise and complete statement of:

_____ (a) The health, dental or vision care services and any other benefits to which the insured is entitled on a nondiscriminatory basis, including benefits mandated by state or federal law.

_____ (c) The limitations on the scope of health, dental or vision care services and any other benefits to be provided, including an explanation of any deductible or copayment feature.

_____ (d) All restrictions relating to preexisting condition limitations or exclusions, or a statement that there are no preexisting condition limitations or exclusions if there are none under the health, dental or vision benefit plan.

_____ (e) The locations where, and the manner in which, health, dental or vision care services and other benefits may be obtained.

_____ (g) The criteria by which an insured may be disenrolled or denied enrollment. This provision shall apply to carriers, including dental and vision carriers.

(h) The involuntary disenrollment rate among insureds of the carrier. This provision shall apply to carriers, including dental and vision carriers.

_____ 1. For the purposes of 211 CMR 52.13(3)(h), carriers shall exclude all administrative disenrollments, insureds who are disenrolled because they have moved out of a health plan's service area, insureds whose continuation of coverage periods have expired, former dependents who no longer qualify as dependents, or insureds who lose coverage under an employer-sponsored plan because they have ceased employment or because their employer group has cancelled coverage under the plan, reduced the numbers of hours worked, become disabled, retired or died.

_____ 2. For the purposes of 211 CMR 52.13(3)(h), the term "involuntary disenrollment" means that a carrier has terminated the coverage of the insured due to any of the reasons contained in 211 CMR 52.13(3)(i)2. and 3.

(i) The requirement that an insured's coverage may be canceled, or its renewal refused, may arise only in the circumstances below. This provision shall apply to carriers, including dental and vision carriers.

_____ 1. 1.failure by the insured or other responsible party to make payments required under the contract;

_____ 2. misrepresentation or fraud on the part of the insured;

_____ 3. commission of acts of physical or verbal abuse by the insured which pose a threat to providers or other insureds of the carrier and which are unrelated to the physical or mental condition of the insured; provided, that the commissioner prescribes or approves the procedures for the implementation of the provisions of 211 CMR 52.13(3)(i)3;

_____ 4. relocation of the insured outside the service area of the carrier; or

_____ 5. non-renewal or cancellation of the group contract through which the insured receives coverage.

_____ (m) A description of the carrier's, including a dental or vision carrier's, method for resolving insured inquiries and complaints;

_____ (n) A summary description of the procedure, if any, for out-of-network referrals and any additional charge for utilizing out-of-network providers. This provision shall apply to carriers, including dental and vision carriers.

_____ (o) A summary description of the utilization review procedures and quality assurance programs used by the carrier, including a dental or vision carrier, including the toll-free telephone number to be established by the carrier that enables consumers to determine the status or outcome of utilization review decisions.

_____ (p) A statement detailing what translator and interpretation services are available to assist insureds, including that the carrier will provide, upon request, interpreter and translation services related to administrative procedures. The statement must appear in at least Arabic, Cambodian, Chinese, English, French, Greek, Haitian-Creole, Italian, Lao, Portuguese, Russian and Spanish. This provision shall apply to carriers, including dental and vision carriers. **(See also M.G.L. c. 176O, §15 (k))**

## DEPENDENT ELIGIBILITY – Applicable to Vision Stand-Alone Only

_____ According to M.G.L. c. 175, § 110(P), "[a] blanket or general policy of insurance described in subdivision (A), (C) or (D), except policies or certificates which provide **stand-alone dental services** or coverage to Medicare or other governmental programs which shall be delivered, issued or renewed in the commonwealth, shall provide, as benefits to all group members having a place of employment in the commonwealth, coverage to persons under 26 years of age or for 2 years after the end of the calendar year in which such persons last qualified as dependents under 26 U.S.C. 106, whichever occurs first."

**Please identify the section(s) and page number(s) of the evidence of coverage(s) that clearly identify the above-noted statute (See also Bulletin 07-01 and 08-01)**

_____ According to M.G.L. c. 176A, § 8BB and M.G.L. c. 176B, § 4BB, "[a]ny subscription certificate under a group nonprofit hospital service agreement, except certificates which provide stand-alone dental services, supplemental coverage to Medicare or other governmental programs, that is delivered, issued or renewed in the commonwealth, shall provide, as benefits to all group members having a principal place of employment within the commonwealth, coverage to persons under 26 years of age or for 2 years after the end of the calendar year in which such persons last qualified as dependents under 26 U.S.C. 106, whichever occurs first."

## ADVANCE FILING OF EVIDENCE OF COVERAGE [211 CMR 52.13(8)]:

A carrier, including a dental or vision carrier, shall submit all evidences of coverage to the Bureau at least 30 days prior to their effective dates.

_____ **Please confirm that the carrier will comply with this requirement.**

## DATES REQUIRED [211 CMR 52.13(10)]:

Every evidence of coverage described in 211 CMR 52.13 must contain the effective date, date of issue and, if applicable, expiration date.

_____ **Please identify the page where such information may be located.**

## INTERNET WEBSITES [211 CMR 52.13(4)]:

_____ If the carrier, including any dental or vision carrier, refers the insured to resources where the information described in the evidence of coverage can be accessed, including, but not limited to, an internet website, such carrier must be able to demonstrate compliance with the following with respect to the internet website, where the term "internet website" shall include "intranet website," "electronic mail," or "e-mail":

(a) The carrier has issued and delivered written notice to the insured that includes:

1. All necessary information and a clear explanation of the manner by which insureds can access their specific evidences of coverage and any amendments thereto through such internet website;
2. A list of the specific information to be furnished by the carrier through an internet website;
3. The significance of such information to the insured;
4. The insured's right to receive, free of charge, a paper copy of evidences of coverage and any amendments thereto at any time;
5. The manner by which the insured can exercise the right to receive a paper copy at no cost to the insured; and
6. A toll-free number for the insured to call with any questions or requests.

(b) The carrier has taken reasonable measures to ensure that the information and documents furnished in an internet website is substantially the same as that contained in its paper documents. All notice and time requirements applicable to evidences of coverage shall apply to

information and documents furnished by an internet website.
(c) The carrier has taken reasonable measures to ensure that it furnishes, upon request of the insured, a paper copy of evidences of coverage and any amendments thereto.
**Does the carrier refer the insured to resources where the information described in the evidence of coverage can be accessed via the web. If so, please respond to the above issues.**

## GROUP PLANS [211 CMR 52.13(5)]:

A carrier, including a dental and vision carrier, shall always deliver at least one evidence of coverage to the group representative of a group plan, notwithstanding the provisions of 211 CMR 52.13, 211 CMR 52.14, or 211 CMR 52.15.

_____ **Please confirm that the carrier complies with this requirement**

## GENERAL NOTICE OF MATERIAL CHANGES [211 CMR 52.13(6)]:

A carrier, including a dental and vision carrier, shall provide to at least one adult insured in each household residing in Massachusetts, or in the case of a group policy, to the group representative, notice of all material changes to the evidence of coverage.

_____ **Please confirm that the carrier complies with this requirement**

## ADVANCE NOTICE OF MATERIAL MODIFICATIONS [211 CMR 52.13(7)]:

A carrier, including a dental or vision carrier, shall issue and deliver to at least one adult insured in each household residing in Massachusetts, or in the case of a group policy, to the group representative, prior notice of material modifications in covered services under the health, dental or vision plan, at least 60 days before the effective date of the modifications. Such notices shall include the following:

(a) any changes in clinical review criteria; and

(b) a statement of the effect of such changes on the personal liability of the insured for the cost of any such changes.

_____ **Please confirm that the carrier complies with this requirement and highlight the section of the evidence of coverage that addresses the above-noted provision in detail.**

## REQUIRED DISCLOSURES [211 CMR 52.14]:

(1) A carrier shall provide to at least one adult insured in each household upon enrollment, and to a prospective insured upon request, the following information:

_____ (c) the voluntary and involuntary disenrollment rate among insureds of the carrier;

1. For the purposes of 211 CMR 52.14(1)(c), carriers shall exclude all administrative disenrollments, insureds who are disenrolled because they have moved out of a health plan's service area, insureds whose continuation of coverage periods have expired, former dependents who no longer qualify as dependents, or insureds who lose coverage under an employer-sponsored plan because they have ceased employment or because their employer group has cancelled coverage under the plan, reduced the numbers of hours worked, retired or died.

2. For the purposes of 211 CMR 52.14(1)(c), the term "voluntary disenrollment" means that an insured has terminated coverage with the carrier for nonpayment of premium.

3. For the purposes of 211 CMR 52.14(1)(c), the term "involuntary disenrollment" means that a carrier has terminated the coverage of the insured due to any of the reasons contained in 211 CMR 52.13(3)(i)2. and 3.

(d) A notice to insureds regarding emergency medical conditions that states all of the following:

1. that insureds have the opportunity to obtain health care services for an emergency medical condition, including the option of calling the local pre-hospital emergency medical service system by dialing the emergency telephone access number 911, or its local equivalent, whenever the insured is confronted with an emergency medical condition which in the judgment of a prudent layperson would require pre-hospital emergency services;

2. that no insured shall in any way be discouraged from using the local pre-hospital emergency medical service system, the 911 telephone number, or the local equivalent;

3. that no insured will be denied coverage for medical and transportation expenses incurred as a result of such emergency medical condition; and

4. if the carrier requires an insured to contact either the carrier or its designee or the primary care physician of the insured within 48 hours of receiving emergency services, that notification already given to the carrier, designee or primary care physician by the attending emergency physician shall satisfy that requirement.

(2) The information required by 211 CMR 52.14 may be contained in the evidence of coverage and need not be provided in a separate document.

(3) Every disclosure described in 211 CMR 52.14 must contain the effective date, date of issue and, if applicable, expiration date.

(7) A carrier, including a dental or vision carrier, shall provide to a health, dental or vision care provider, a written reason or reasons for denying the application of any health, dental, or vision care provider who has applied to be a participating provider. **(See also M.G.L. c. 176O, § 15(i))**

## MINIMUM CREDITABLE COVERAGE NOTICES – (BULLETIN 2008-02)

As of January 1, 2009, the Massachusetts Health Care Reform Law requires each Massachusetts resident, eighteen (18) years of age and older, to have health coverage that meets the Minimum Creditable Coverage ("MCC") standards set by the Commonwealth Health Insurance Connector ("Connector"), unless those plans meeting these standards are deemed to not be affordable to that person.

In order to help individuals determine if the health coverage they have or intend to purchase is sufficient to satisfy the individual mandate...all commercial health insurers, Blue Cross and Blue Shield of Massachusetts, Inc., and Health Maintenance Organizations (collectively "carriers") that offer or renew an individual or group insured health plan in Massachusetts, as defined in M.G.L. c. 176N, with coverage effective on or after February 1, 2008...are to disclose to insureds and potential insureds a plan's MCC status and whether the plan satisfies the individual coverage mandate of the Massachusetts Health Care Reform Law.

The insured health plan's MCC status will be based on compliance with applicable standards in effect on and after January 1, 2009 as set forth by the Connector either by regulation or administrative bulletin.

_____ In the case of an employer-sponsored group insured health plan, said disclosure requirement also applies to marketing materials that describe the insured health plan benefits that are used during the employer's open enrollment period.

**Please confirm that the carrier complies with this requirement.**

_____ The filed product **meets MCC standards**;

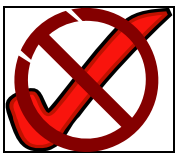
_____ The filed product **does not meet MCC standards**;

_____ The filed product **is not considered a "health plan", as defined in M.G.L. c. 176N**.

**Please place a checkmark (√) next to the statement indicating whether the filed plan product design is sufficient to satisfy the Minimum Creditable Coverage ("MCC") standards set by the Commonwealth Health Insurance Connector.**

## IF AN INSURED ACCIDENT AND SICKNESS PLAN IS NOT CONSIDERED A "HEALTH PLAN", AS DEFINED IN M.G.L. C. 176N

_____ The following disclosure notice must be included on the face or the first page of the text of the policy or certificate or on any required notice submitted with the product in substantially the same language and format: :



This health plan, alone, **does not meet Minimum Creditable Coverage standards** and **will not satisfy** the individual mandate that you have health insurance. Please see page # for additional information.

_____ In addition, the following disclosure shall be placed within the body of the policy, certificate, or schedule of benefits in substantially the same language and format:

**As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).**

This plan is not intended to provide comprehensive health care coverage and **does not meet Minimum Creditable Coverage standards**, even if it does include services that are not available in the insured's other health plans.

**If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.**